LIBBY HOWELL, ED.D
Licensed Psychologist

MEDICAL INFORMATION

CLIENT NAME:_____ **DATE OF INTAKE**:_____

Have you seen a doctor within the past year? Yes_____ No_____
Why have you seen a doctor?

Doctor's Name_____ **Phone**_____

Doctor's Name_____ **Phone**_____

Are you taking any medications (prescription or over the counter)? Yes_____ No_____
Is so, please list them by name and dosage:

Medication	Dosage
1.	1.
2.	2.
3.	3.
4.	4.

Do you have any allergies to anything? Yes_____ No_____
Please describe any allergy problems you may have:

SUBSTANCE ABUSE HISTORY

Substance	Currently Use	Amount per Day	Past Use	Never Used
Tobacco (any form)				
Alcohol				
Caffeine (coffee, colas, etc.)				
Recreational Drugs (marijuana, cocaine, meth, etc.)				

Have you ever participated in treatment for drug or alcohol use? Yes_____ No_____
If so, when did you have treatment? Dates:_____
Explain what happened: